171 Pelvic Pain

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Definition

Pelvic pain is abdominal pain located below the level of the umbilicus including, frequently, lower back pain with or without radiation into the thighs. Such pain may be acute, chronic, or intermittent and may be simulated by gastrointestinal disease such as diverticulitis or by lumbosacral arthritis. *Dyspareunia* is pelvic pain associated with intercourse. *Dysmenorrhea* is painful menstruation. Primary dysmenorrhea is painful menstruation when the pelvic examination is normal. Secondary dysmenorrhea is diagnosed in the presence of gynecologic disease and is usually associated with such conditions as endometriosis, adenomyosis, and pelvic inflammatory disease.

Technique

A careful history is important. The intensity, onset (sudden or gradual), and relation to past events and adjacent organ systems should be carefully evaluated. Changes in the menstrual cycle, relation to the menstrual flow, relation to coitus, a history of previous pelvic surgery or of a recent gonorrheal infection, the type of contraceptive used, the sexual history, long periods of involuntary infertility—all of these factors and others are important in evaluating pelvic pain that may be of gynecologic origin.

If the complaint is dyspareunia, a detailed description of the pain and its relationship to penile insertion must be obtained. Is the discomfort at the vaginal introitus and present at the moment of entry? Or is the pain deep in the pelvis with the feeling that something tender is being hit? Or is this a residual feeling of congestion and heaviness, particularly throughout the pelvis following intercourse without orgasm? The presence or absence of fever aids significantly in establishing both diagnosis and treatment.

Basic Science

A feeling of pain or discomfort in the pelvis in a female patient may be part of a normal physiologic mechanism, may be associated with a medical crisis for which emergency therapy is needed to save the patient's life, may be associated with a chronic pelvic problem, or may remain forever and mysteriously unexplained. It should be understood, particularly by men, that some degree of pelvic discomfort and pelvic pain is a normal and natural part of human femaleness. Men rarely experience pelvic discomfort, whereas women frequently do. Pelvic pain in the female, therefore, may or may not require intervention and treatment.

Evaluation of pelvic pain is also made more difficult because the characteristics of pelvic pain are often difficult for women to describe and localize accurately. In all probability, the explanation for this lies in the fact that there are no great concentrations of sensory nerve ganglia in the pelvis, such as one encounters in the periosteum of the bone or the conjunctiva or the skin, especially perianal skin. Thus, it is difficult for the pain-perceiving centers in the brain to make a sharp differentiation as to the location, type, and severity of the pain. This is the primary reason that ovarian carcinoma has such a poor prognosis. It causes no discomfort in the early stages, even though the tumor has grown to a large size. In contrast, great discomfort can be caused by small implants of endometriosis on the uterosacral ligaments.

Pelvic pain may be associated with a variety of acute and chronic gynecologic and nongynecologic organic diseases at the same time. It should also be stated that many of these diseases may be present without pelvic pain. Some women with chronic pelvic inflammatory disease will have pelvic pain, and some will not. Some women with extensive endometriosis will have pelvic pain, and some will not. The same is true of relaxations and prolapse.

Primary dysmenorrhea is *not* present when the menstrual cycles are anovulatory. For several cycles after the menarche, menstruation is likely to be painless because the cycles are anovulatory. When dysmenorrhea begins in young girls and the pelvic examination is normal, one can assume that ovulatory cycles are also present. It should be emphasized, however, that severe dysmenorrhea in young girls may be associated with cryptomenorrhea (hidden menstruation) because of an anomalous development (imperforate hymen, rudimentary uterine horn).

Dysmenorrhea is described as an intermittent cramping discomfort in the lower abdomen and pelvis. It may also be associated with a bearing-down sensation, backache, and epigastric discomfort and vomiting. Discomfort and cramping in the legs are not uncommon. A syndrome of "premenstrual tension" often precedes the appearance of menstrual flow. This syndrome may incude headaches, constipation, fluid retention, weight gain, abdominal bloating, mild depression, and breast tenderness. Often, the constipation will be relieved with several loose stools just before the menstrual flow begins.

Clinical Significance

A complaint of pelvic pain deserves a careful evaluation at any age, but the occurrence of new pelvic pain in a premenarchial girl or a postmenopausal women is more often found associated with significant pathology and should never be dismissed lightly.

In addition to a careful gynecologic history, a complete pelvic examination will be helpful in evaluating the complaint of pelvic pain. One should look for irritating lesions of the vulva and vagina, vaginal relations and uterine malpositions, evidence of stenosis of the cervical canal, adnexal

masses, and tenderness and indurated and nodular pelvic tissue.

Unfortunately, it is not always possible to be certain about the presence or absence of disease in the pelvis, even with a properly performed examination on a completely cooperative patient. Organic pelvic disease may be present even though the pelvis is judged to be normal at the time of the examination. Also, organic pelvic disease may be absent in women who have suspicious findings on pelvic examination. Therefore, laparoscopy has a definite place in the examination of patients with pelvic pain, as does magnetic resonance imaging.

Reference

Jones GS, Jones HW. Novak's textbook of gynecology. 10th ed. Baltimore: Williams and Wilkins, 1981.